WC-102 REQUEST FOR DOCUMENTS TO PARTIES

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR DOCUMENTS TO PARTIES

Instructions: **NEITHER THE RESPONSE NOR REQUEST SHOULD BE FILED WITH THE BOARD.** Prior to a request for hearing being filed in a claim, the parties shall be entitled to receive from each other the documents specified in this form. These documents shall be provided without cost as requested within 30 days of the date of the certificate of service. **FAILURE OF THE PARTIES TO PROMPTLY EXCHANGE THESE DOCUMENTS MAY RESULT IN THE ASSESSMENT OF PENALTIES AND ATTORNEY'S FEES [SEE BOARD RULE 102(F)(1)]**.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address

EMPLOYER	Name	**INSURER / SELF-INSURER**	Name
Address		**CLAIMS OFFICE**	Name
		Address	
ATTORNEY FOR EMPLOYEE	Name	**ATTORNEY FOR EMPLOYER**	Name
Address		Address	

B. PRODUCTION OF DOCUMENTS

1. The employee hereby requests production of the following documents in the possession of the employer / insurer:

- ❑ Form WC-1
- ❑ Form WC-2
- ❑ Form WC-2a
- ❑ Form WC-3
- ❑ Form WC-4
- ❑ Form WC-6
- ❑ Form WC-20a
- ❑ Form WC -R1, 2 and all rehabilitation supplier reports
- ❑ Actual wage records of employee:
  - ❑ Employee, from _____ / _____ / _____ to _____ / _____ / _____
  - ❑ Similarly situated employee, from _____ / _____ / _____ to _____ / _____ / _____
- ❑ Copy of job description / analysis submitted to authorized treating physician
- ❑ Form WC-104
- ❑ Form WC-200a
- ❑ Form WC-200b
- ❑ Form WC-205
- ❑ Form WC-240 with supporting documents
- ❑ Form WC-243
- ❑ Reports prepared pursuant to Rule 200.1.(f)
- ❑ Medical records pursuant to Board Rule 200 (f) (2)
- ❑ Form WC- P1, 2 or 3 utilized by the employer on the date of accident

2. The employer / insurer hereby requests production of the following document in the possession of the employee / claimant:

- ❑ Wage records applicable to calculation of TPD benefits (from _____ / _____ / _____ to _____ / _____ / _____)
- ❑ Medical records pursuant to Board Rule 200 (f) (1)

C. CERTIFICATION

❑ I hereby certify that I have this day sent a copy of this document to the above-named parties.

Print Name	Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).